Greater Minnesota Telehealth/e-Health Broadband Initiative (GMBTI)

FCC Rural Health Care Pilot

Quarterly Report

5/30/2012

NOTE: Quarterly Report updates/revisions/changes from prior quarterly report included as either highlighted content or dated and sorted in reverse chronological order.

1. Project Contact and Coordination Information

a. Identify the project leader(s) and respective business affiliations.

Project Leaders: Mark Schmidt, Project Coordinator, Manager
Jeff Plunkett, Associate Project Coordinator
SISU Medical Systems, Inc.
5 West 1st Street, Suite 200
Duluth, Minnesota 55802

Change in project leaders was completed and recognized by USAC, 3/30/2012; GMTBI steering committee approved the following change: Kap Wilkes was replaced as Project Coordinator by Mark Schmidt, effective at the time of the steering committee's approval.

b. Provide a complete address for postal delivery and the telephone, fax, and e-mail address for the responsible administrative official.

Mark Schmidt
SISU Medical Systems
5 West First Street, Suite 200
Duluth, MN 55802
Telephone: (218) 529-7900
Fax: (218)529-7920
kwilkes@sisunet.org

c. Identify the organization that is legally and financially responsible for the conduct of activities supported by the award.

SISU Medical Systems, Inc.

d. Explain how project is being coordinated throughout the state or region.

The Greater Minnesota Telehealth Broadband Initiative (GMTBI) Steering Committee is organized through a Memorandum of Agreement to act as an approving body for decisions and actions needed through the RFP/funding process as well as council to the Project Coordinator, Kap Wilkes, on behalf of the lead organization, SISU Medical Systems. The GMBTI Steering Committee meets in bi-weekly phone conferences for discussion and decisions or on an as needed basis to council on management of the project and make voting decisions during any competitive bidding procedures.

The voting members of the GMTBI Steering Committee members were expanded in October, 2011 to include the three unrepresented regional hub organizations The Chair position will continue to be a non-voting position. Currently the voting membership includes:

1. Ron Brand, Minnesota Association of Community Mental Health Programs, representing over 120 mental health centers and satellites
2. Jon Linnell, North Region Health Alliance (NRHA), representing 19 hospitals in Minnesota and North Dakota (overlap with SISU, MTN)
3. Debra Ranallo, Medi-sota, Inc., non-profit consortium comprised of 30+ hospitals in Minnesota and South Dakota
4. Mark Schmidt, SISU Medical Systems, Inc., a non-profit consortium of 16 medical centers that share information technology resources (overlaps with MTN, NRHA, and Medi-sota, Inc.)

5. Matt Schumacher, Altru Health Systems, located in Grand Forks, North Dakota.
6. Dennis Smith, Essentia Health System, representing the Fargo hospital POP location, Essentia is headquartered in Duluth, MN.
7. Glenn Anderson, Northern Pines Mental Health Center, Brainerd, MN
8. Gregg Price, Rice Memorial Hospital, Willmar, MN

The non-voting regular participants of the GMTBI Steering Committee are:

1. ~~Karen Welle, Minnesota Department of Health, Office of Rural Health and Primary Care~~
2. Mark Schoenbaum, Minnesota Department of Health, Office of Rural Health and Primary Care
3. Stuart Speedie, University of Minnesota, Center for Health Informatics, and Minnesota Telehealth Network
4. Zoi Hills, University of Minnesota, Center for Health Informatics Minnesota Telehealth Network
5. Myron Lowe, University of Minnesota, Information Technology
6. Jeff Plunkett, SISU Medical Systems
7. Maureen Ideker, Essentia Health, Steering Committee Chair

Temporary non-voting participants of the GMTBI Steering Committee include any active RFP's IT staff or administrators. The GMTBI Steering Committee and any other interested facilities representatives are kept up to date through bi-weekly steering committee meetings and a shared document library through a customized Google Group webpage. These bi-weekly meetings include a regular Project Coordinator Update of progress within the phases, any USAC updates or FCC information. The GMTBI project includes 144 termination points. The health care organizations participating in the GMTBI RHCPP include Critical Access Hospitals, community health clinics, regional hospitals, community mental health organizations, and healthcare data centers. The Project Coordinator also holds monthly project coordination phone conferences for all participating organizations IT staff and Administrator contacts.

2. Identify all health care facilities included in the network.

Addendum A: Spreadsheet of participating organizations includes all three phases, as of 9.2011, after all eligibility decisions were completed there are a total of 131 unique terminations point included within the three phases, including 4 in phase 1, 14 in phase 2, and 113 in phase 3.

a. Provide address (including county), zip code, Rural Urban Commuting Area (RUCA) code (including primary and secondary), six-digit census tract, and phone number for each health care facility participating in the network.

b. For each participating institution, indicate whether it is:

i. Public or non-public;

ii. Not-for-profit or for-profit;

iii. An eligible health care provider or ineligible health-care provider with an explanation of why the health care facility is eligible under section 254 of the 1996 Act and the Commission's rules or a description of the type of ineligible health care provider entity.

3. Network Narrative: In the first quarterly report following the completion of the competitive bidding process and the selection of vendors, the selected participant must submit an updated technical description of the communications network that it intends to implement, which takes into account the results its network design studies and negotiations with its vendors. This technical description should provide, where applicable:

a. Brief description of the backbone network of the dedicated health care network, *e.g.* MPLS network, carrier-provided VPN, a SONET ring;

b. Explanation of how health care provider sites will connect to (or access) the network, including the access technologies/services and transmission speeds;
c. Explanation of how and where the network will connect to a national backbone such as NLR or Internet2;
d. Number of miles of fiber construction, and whether the fiber is buried or aerial;
e. Special systems or services for network management or maintenance (if applicable) and where such systems reside or are based.

The Network Diagram is available on the USAC GMTBI Sharepoint document library along with the RFP that describes the network. Additional network narrative will be developed over the coming quarters.

4. List of Connected Health Care Providers: Provide information below for all eligible and noneligible health care provider sites that, as of the close of the most recent reporting period, are connected to the network and operational.

a. Health care provider site;
b. Eligible provider (Yes/No);
c. Type of network connection (*e.g.*, fiber, copper, wireless);
d. How connection is provided (*e.g.*, carrier-provided service; self-constructed; leased facility);
e. Service and/or speed of connection (*e.g.*, DS1, DS3, DSL, OC3, Metro Ethernet (10 Mbps);
f. Gateway to NLR, Internet2, or the Public Internet (Yes/No);
g. Site Equipment (*e.g.*, router, switch, SONET ADM, WDM), including manufacturer name and model number.
h. Provide a logical diagram or map of the network.

Phase 2: SISU-Duluth-Core Hub go live was planned for September 2011; this has been delayed to November 2011 due to the complexity of the hardware/software MPLS programming. The Altru-Grand Forks-Regional Hub go live is planned for October 2011. The circuit connections of the remaining 10 HCP's are planned for November 2011. As of 12/31/2011, a total of 18 termination points, including the core hub are live and operational and connected as a broadband network.

Phase 1: Murray County Medical, Rice Memorial Hospital, and Sibley Medical Center, at the close of the most recent reporting period, are connected to the network. Johnson Memorial Hospital is connected to the network.

The detail of each connection (a-e) is provided within the 466A package for RFP00, Network diagram, and contract documents. All of these documents have been uploaded and are available on the USAC RHCPP sharepoint site.

5. Identify the following non-recurring and recurring costs, where applicable shown both as budgeted and actually incurred for the applicable quarter and funding year to-date.

a. Network Design
b. Network Equipment, including engineering and installation
c. Infrastructure Deployment/Outside Plant
i. Engineering
ii. Construction
d. Internet2, NLR, or Public Internet Connection
e. Leased Facilities or Tariffed Services
f. Network Management, Maintenance, and Operation Costs (not captured elsewhere)
g. Other Non-Recurring and Recurring Costs

For each phase of the GMTBI pilot project proposal, the actual costs correspond to the approved costs listed within the network cost worksheet and 466A Attachment and Funding Letter. A GMTBI summary of total costs, budgeted and actual will be provided for Phase 1 and Phase 2 in the ~~2011 Qtr 4 report~~. 2012 Qtr 1 report.

6. Describe how costs have been apportioned and the sources of the funds to pay them:

a. Explain how costs are identified, allocated among, and apportioned to both eligible and ineligible network participants.

All participants are 100% eligible.

b. Describe the source of funds from:

i. Eligible Pilot Program network participants

Network participant's source of fund to cover costs is the individual organizations operational budget.

ii. Ineligible Pilot Program network participants NA

c. Show contributions from all other sources (*e.g.*, local, state, and federal sources, and other grants). NA

i. Identify source of financial support and anticipated revenues that is paying for costs not covered by the fund and by Pilot Program participants.

NA

ii. Identify the respective amounts and remaining time for such assistance.

d. Explain how the selected participant's minimum 15 percent contribution is helping to achieve both the selected participant's identified goals and objectives and the overarching goals of the Pilot Program.

Not Applicable at this point in time.

7. Identify any technical or non-technical requirements or procedures necessary for ineligible entities to connect to the participant's network.

No ineligible entities are being considered for connecting to the participant's network during the pilot project.

8. Provide an update on the project management plan, detailing:

a. The project's current leadership and management structure and any changes to the management structure since the last data report; and

GMTBI Leadership and Management Structure (Details in paragraphn1-d)	
	March 2012 GMTBI Leadership and Mgmt Structure: In February, 2012, Kap Wilkes was replaced as Project Coordinator by Mark Schmidt, effective upon approval of USAC and the GMTBI Steering Committee.
	December 2011 GMTBI Leadership and Mgmt Structure: no changes
	September 2011 GMTBI Leadership and Mgmt Structure: no changes
	June 2011 GMTBI Leadership and Mgmt Structure: no changes
	March 2011 GMTBI Leadership and Mgmt Structure: In February, 2011, Mark Schmidt was replaced as Project Coordinator by Kap Wilkes, effective upon approval of USAC and the GMTBI Steering Committee.
	December 2009 GMBTI Leadership and Mgmt Structure: GMTBI Steering Committee is complete with a signed Memorandum of Agreement in place. The GMBTI Steering Committee meets regularly and will guide the project coordinator in the management of the project. There are 5 voting members within this committee; one from each participating network of HCPs. Additionally there are regularly contributing members from either state organizations or hospitals providing input and information. Mark Schmidt is acting as Project Coordinator, Jeff Plunkett and Kap Wilkes are acting as Associated Project Coordinators, SISU Medical Systems. Jeff Plunkett brings technical knowledge and skills that will support the RFP writing, vendor selection, and network implementation management. Kap Wilkes brings project management knowledge and will manage communication, documentation and reporting of the overall project and the invoicing process. Karen Welle, of MN Dept of Health, Office of Rural Health and Primary Care, has been removed as Associate Project Coordinator, replace by Kap Wilkes, SISU Medical Systems.

b. In the first quarterly report, the selected applicant should provide a detailed project plan and schedule. ***The schedule must provide a list of key project deliverables or tasks, and their anticipated completion dates. Among the deliverables, participants must indicate the dates when each health care provider site is expected to be connected to the network and operational.*** **Subsequent quarterly reports should identify which project deliverables, scheduled for the previous quarter, were met, and which were not met. In the event a project deliverable is not achieved, or the work and deliverables deviate from the work plan, the selected participant must provide an explanation. 423 Non-recurring costs are flat charges incurred only once when acquiring a particular service or facility. Recurring usage or length of service contract.**

GMTBI Project Work Plan
Key project deliverables and timeline w/ explanation of delays or changes.

In its project work plan, the GMTBI envisioned the creation of a strong integrated rural telehealth/e-Health infrastructure that will allow providers to exchange health care data and will ultimately allow any patient in any community in Minnesota to connect to any provider in Minnesota and beyond. Planning for achieving the goals set forth by the GMTBI is underway.

I. RFP00 : 4 HCP's + 1 Regional POP

December 2011 Update: -

1. **Actual**:
   - **a.** Additional submissions have been completed, October - December 2011.

September 2011 Update: -

2. **Actual**:
   - **a.** Additional submissions have been completed, July - September 2011.

June 2011 Update:

3. **Actual**:
   - **a.** Additional submissions have been completed, April – June 2011.

March 2011 Update:

4. **Actual**:
   - **a.** Additional submissions have been completed in January – March 2011.

December 2010 Update:

5. **Actual**:
   - **a.** Additional submissions have been completed in November 2010 and December 2010.

September 2010 Update:

6. **Actual**:
   - **a.** Invoicing process for the 4 HCP's and associated vendors started with July 2010 Submissions. This first submission included all of the months of the contract through April or May 2010. Submission included using the USAC invoice form, project coordinator signature, supporting documentation uploaded to the USAC sharepoint site and providing the vendor with the PC signed invoice.
   - **b.** Additional submissions have been completed in September 2010 and October 2010.
   - **c.** It is not known at the writing of this quarterly report how much, if any, USAC funds have been released to the participating vendors related to these 4 HCP's.
   - **d.** It is not the responsibility of the project coordinators or HCP's to confirm that the vendors have received their 85% payment. However, it is our responsibility to provide accurate supporting documentation to USAC and submit invoices correctly and accurately to USAC and the vendor.

June 2010 Update:

Actual:

a. written and approved by GMTBI Steering Committee, reviewed and posted by USAC for competitive bidding for 28 days: April-May 2009
b. Competitive Bidding and Vendor selection: Mid-June 2009
c. HCP/Telco Vendor contracts signed: June-July 2009
d. HCP GMTBI Authorization for Payment and Certification of Eligibility form completed by participating HCPs and Assoc. Project Coordinator: May 2010
e. 466A+Attachment and NCW submitted -May 2010
f. There was significant delay between signed contracts and submitting the 466 package due to many factors that were significant as individual issues and proved to be complex in combination:
    1. Change in a vendor contract for the 'last mile' for 1 HCP.
    2. Back-order delay for switch/router equipment.
    3. Vendor 'miss-billing' of recurring monthly circuit costs took months to resolve.
    4. Vendor de-activating circuit due to lack of 100% payment took months to resolve.
    5. Vendor charging late fees and sending HCP account to collection agency due to lack of 100% payment took months to resolve.
    6. Delay in vendor response for Certification of Eligible Vendor.
    7. Lack of understanding of the USAC funding process by the project coordinators, steering committee, and USAC coach caused unexpected requirements and increased workload.
    8. Communication with Telco Vendors was slow and caused delays in problem solving.
    9. Lack of funding for project management and corresponding efforts to locate funding resources caused delays in funding process.
    10. Turn-over in the GMTBI leadership and management caused loss of knowledge and delay in funding process.
    11. Unknown requirement of Sustainability Plan including 10 year budget forecast added increased work load.

Actual: Funding Commitment Letter was issued by USAC on July 1, 2010

a. The issuance of the FCL was delayed from May – June due to required revisions to the GMTBI Sustainability Plan. A 10year budget forecast was required along with extensive revisions in the narrative. The revised GMTBI Sustainability Plan ver 5.27.2010 was accepted by USAC in June 2010.
b. 467 Form submitted and approved by USAC: July 2010

Planned:

a. Successful first USAC invoicing completed for each Telco Vendor by July 31, 2010

March 2010 Update: GMTBI Project Coordinators continue to work directly with the USAC Coach to complete documentation of the 466A package and competitive bidding process. We are expecting approval and issuance of the Funding Commitment Letter no later than June 1, 2010. Assoc Project Coordinator is working with the four participating sites to create a reference document to be used by both the HCP's and Project Coordinator: Authorization for Payment and Certification of Eligibility. This document contains the same vendor, account, and cost information as the 466A and Network Cost Worksheet. We are expecting this information to be identically reflected within the Funding Commitment Letter.

December 2009 GMBTI work plan:

Complete documentation for RFP (00) and receive Funding Commitment Letter in order to begin invoice reimbursement process with initial participants. This installation of the proposed circuits (and thus also the 466 documentation) was significantly delayed due to a last minute change in the last-mile service provider. This has now been rectified, the circuits installed and accompanying hardware installed.

Sept 2011 Format of Workplan documentation revised to be organized by steps instead of by date of update. Pertinent information from prior workplans has been included in this revised format. Prior quarter updates have been removed to improve 'readability' workplan.

II. RFP01 : PHASE 2 Central Hub + 1 Regional POP + 3 HCPs		
Project Steps	**Planned Dates**	**Actual Date**
1. **GMTBI Steering Committee approved the RFP01 design and HCP listing**.		**6/10/2010**
2. **Submit 465-A approval and RFP for USAC approval of eligibility and posting for competitive bidding for 28 day.**	~~July 2010~~ ~~August, 2010~~	**9/23/2010**
a. USAC has been reviewing the RFP prior to posting as of 6/25/2010 with additional fine-tuning completed by assoc. project coordinator on 7/16/2010. Requested approval for posting for competitive bidding **b.** Final Approval of the 465 and 465-A had many edits for editing termination addresses and eligibility questions. Editing of the form to get the addresses correct, etc, was completed late.		
c. Requirements of Community Mental Health questionnaires being completed for each termination location were identified in.	July 2010	
d. Letter of Agency requirement to include all termination points. This was identified as needed when the two community mental health organizations had 5-9 termination points and their one organization LOA did not include the addresses/locations of those points. e. The LOA's were gathered and uploaded to USAC sharepoint	August 2010.	
f. USAC review and verification of eligibility of the community mental health organizations. Two locations with the HDC organization were classified as ineligible in early September, 2010. On 9/8/2010 the GMTBI steering committee decided to reclassify these two sites as ineligible in order to not delay the RFP posting. The sites were ultimately removed from the 465 and 465-A prior to posting of the RFP. g. On 9/10/2010 the RFP was not posted and GMTBI project coordinators requested a status update. Another status update was requested on 9/13/2010. We were given feedback that the RFP would be posted within a day or two. h. 9/17/2010 GMTBI project coordinators were notified that a third site was identified by USAC as being ineligible. The GMTBI project coordinators and GMTBI Steering Committee chair agreed to reclassify that site as ineligible in accordance with the earlier decision regarding the first two ineligible sites in order to get the RFP posted as soon as possible.	August 2010	
i. Because there was only one bid received for the hardware and MPLS programming, the project coordinators, after discussion with USAC , have decided to keep the RFP open for receiving bids for an additional 10 days, 10/22-11/1/2011 .		**11/1/2010**.

Project Steps	Planned Dates	Actual Date
3. **Vendor Selection and Competitive Bidding process** included a task force of IT / network experts will be formed by project coordinators to review and assess the bids. a. Recommendations were made to the GMTBI steering committee. b. Supporting documentation uploaded to USAC sharepoint.	~~August, September, 2010~~	November, 2010
4. **Vendor Selection completed** by Steering Committee members vote on the bid selection.		**Nov. 11, 2010**
5. **HCP/Telco contracts signed and accounts provided**. a. HCPs Letters of Agency updated,:	~~Oct-Dec~~	Dec 2010–Feb 2011.
6. **466A+Attachment and NCW submitted, ,**	~~December 2010 January 2011~~	**March 22, 2011**
7. **466-A Package was approved and the Funding Commitment Letters** delivered to Project Coordinator, HCP contacts and Vendor Contacts.	~~February, 2011April 2011~~	May 2011
8. **Implementation started** for the Central Hub, POP, and HCP hardware was ordered and delivered.	~~, April 2011~~	June, 2011
9. **467 Form submitted** and approved by USAC:~~,~~	~~April 2011,~~	July 2011
10. **Telco Vendor invoice** process started: project coordinator contacted all participating HCP's notifying them of the invoice process and providing them with reference documentation including their HCP's – Telco Vendor's account number, approved hardware + installation cost, and approved circuit cost. Project coordinator also contacted the participating Telco accounts receivable departments to confirm USAC vendor invoice process.	~~September 2011~~	~~**October 2011,**~~ **November 2012**
11. **Completion of Hardware Implementation** of Central Hub, POP, and HCP and circuits live and operational.	~~Sept-Oct2011~~	~~**November, 2011**~~ **December 2012**

March 2010 GMTBI work plan: Project Coordinator and Associate Project Coordinator will complete a redesign of RFP01 to incorporate MLSP technology/programming. This redesign is needed due to changes in known technology since the initial GMTBI network planning. The RFP01 is expected to be completed, approved by the GMTBI Steering Committee, and submitted for bidding no later than June 1, 2010
Participating HCP's network connections are expected to be live and operational in Fall 2010.

December 2009 GMTBI work plan:
The RFP (01) has been submitted to USAC for review and will soon be posted for competitive bidding. This RFP , when completed will form the primary infrastructure for the entire project ; a centrally managed hub sites located in Crookston, Willmar, Minneapolis, and Duluth, MN

Sept 2011 Format of Workplan documentation revised to be organized by steps instead of by date of update. Pertinent information from prior workplans has been included in this revised format. Prior quarter updates have been removed to improve 'readability' workplan.

III. RFP02 : PHASE 3 Network Build-out with 120+ HCPs		
Project Steps	**Planned Dates**	**Actual Date**
1. Participating HCPs surveyed for updated connection needs: **a.** This update and survey of circuit needs has remained on schedule. The participating HCP's were provided with overview and FAQ information and a monthly IT planning project meeting has been taking place: September and October 2010.	~~August – Sept 2010~~	Aug – Oct 2010
2. **RFP02 approved by to GMTBI Steering Committee** and submitted to USAC, including finalized HCP listing and network design.	~~December 2010~~	2/16/2011
3. 465 and 465-A approval submitted to USAC for eligibility determination	~~February, 2011~~	April 2011
4. FCC granted the one year extension of the RHCPP, extending deadline for submitting 466A and requesting funding approval before 6/30/2012.		May 2011
5. Eligibility revision for SISU and NRHA, as consortiums approved, finalized listing of eligible HCP's determined by USAC,		August 2011
6. RFP approved by USAC and posted for bidding for 45days.	~~,June, Aug~~,2011	Posted 9/20/2011 – 11/4/2011
a. Documentation revisions in 466A, NCW, and invoice to show SISU and NRHA as eligible consortium HCP**.**	~~August 2011,~~ ~~September~~,	October, 2011
Comment: In our opinion the duration of obtaining USAC's final eligibility determination of the participating HCP's has put considerable stress on our workplan for the remaining stages of phase 3. We have identified two concerns with our current timeline: 1) our workplan does not have any extra time to absorb additional delays or uncontrolled events. It will be very difficult to complete the complex process of competitive bidding within 6 weeks and the contracting stage of this phase within 8 weeks which are both necessary in order to provide USAC with the 466 Attachment and NCW for review and FCL approval in Spring 2012. 2) This timeline is being driven hard by the increasing pressure from the participating HCP's that are waiting to join the GMTBI backbone. The HCP circuits are needed within the HCP's daily work and the broadband demand is growing. We highlight these concerns and request that USAC remain sensitive and responsive to our request for timely review and/or approval of each stage of this phase so that it stays on track through the FCL. ***GMTBI feels that the future of our network rides on obtaining USAC's FCL in May 2012 so that hardware and circuits can be ordered and turned on during the summer of 2012.***		
7. Competitive Bidding process for vendor selection using IT selection committee and Vendor selection	~~, Oct~~	Nov-Dec,2011
8. GMTBI steering committee approves vendor selection with a vote. Selected vendors notified	~~Nov-~~	Dec 16,2011

Project Steps	Planned Dates	Actual Date
9. HCP/Telco contracts signed and Acct Numbers Provided	~~Dec~~ Jan – Feb 2012	
10. 466A+Attachment and NCW submitted for USAC review	~~Feb~~ Mar-Apr 2012	
11. HCP-GMTBI Circuit and Hardware Cost Reference document. Provided to HCPs by PC	April 2012	
12. Funding Commitment Letter issued by USAC:	, , , ~~Mar~~ May 2012	
1. **467 Form submitted** and approved by USAC:	~~, Mar~~ May 2012	
2. **Implementation started by region or vendor**: starting with two regional hubs and adding in HCP's.	, ~~April-June~~ June-Aug 2012	
3. **Implementation completed** and Live Circuits connected to backbone.	~~, May-June~~, June-August 2012	
4. Telco Vendor Invoice process started	Sept 2012	

December 2010:
COMMENTS regarding the RHCPP 6/30/2011 project deadline:

The GMTBI has been diligently and effectively working on our RHCPP over the past 12 months. And before that, two years were needed to form a working coalition of organizations and setup a Project Coordinator and Steering Committee structure where none had existed. We recognize that our GMTBI – RHCPP project is complex in Minnesota as we strive to make associations with disparate organizations and healthcare networks and build a sustainable network with the objective of improvements in healthcare across our state. The rigor of working within the RHCPP has taken considerably more time and energy than expected and once again we find ourselves behind schedule. Our focus over the past 8 month has been the critical step of designing, competitive bidding, funding approval work, and implementation planning of the network core and related backbone structure. As we have focused on this important second phase, RFP01 we have delayed progress on our third phase, RFP02. Therefore, as we approach this next and final phase, that will add more than 100 termination points with connects into the GMTBI across the entire state, w***e are concerned that we will not be able to complete the bidding and funding approval process prior to the current 6/30/2011 filing deadline without significantly impacting the scope of our project***. We will be either submitting a request for a 1 year extension and/or comment on an already submitted request in January, 2011. We are hopeful that the FCC will approve an extension request to 6/30/3012 so that we can continue with our current network scope and plans. Additionally, if this extension request is approved by the FCC, we are considering if and how to request additional funding to increase the scope of our RHCPP.

CMHC Checklist Comments:
Community Mental Health Organizations USAC Checklist/Questionnaire was added to in order to collect information GMTBI considered pertinent for USAC verification of eligibility. Steering Committee Ron Brand completed the edits, identified those facilities that are anticipated at needing additional information, and gathered the revised questionnaires. These will be uploaded to USAC as supporting documentation at the time that the 465A and 465Attachment are submitted.

Comment: We are concerned with the eligibility verification process that has been used for the

Community Mental Health organizations in this phase. The possibility of being denied eligibility is completely reasonable and the GMTBI is aware of and agreeable with that possibility. What has been a struggle is the large degree of opacity around the criteria and sources of information being used to make the decision. In Minnesota, we are able to supply additional information regarding the services provided at an organization; however, understanding how to differentiate aspects of services for USAC has been difficult- it seems we are not working with a common vocabulary or definitions of eligible services. Our suggestion that may ease the struggle is to ask USAC to provided additional clarification on the information that would enable them to make more informed and timely eligibility decisions. A suggestion is for USAC to share with the participating RHCPP's the criteria that has been found effective in determining eligibility such as, medicare or medicaid numbers, state definitions of Community Mental Health, state CMH association information, and specific examples of what is not eligible.

March 2010 GMTBI work plan: with RHCPP pilot extension to 6/30/2011 we continue to plan submission and implementation of RFP02. We expect to submit the RFP02 for competitive bidding in August 2010. The competitive bidding window will be 60 days due to the extensive size of the proposal.

Participating HCP's network connections are expected to be live and operational in Winter 2010 - Spring 2011.

December 2009 GMBTI work plan:
The RFP (02) is a large proposal, incorporating more than 120 facilities. ***We will not be able to complete this proposal, post for 60 days, and complete the 466 and NWC in time to receive a funding commitment letter prior to the 6/30/2010 filing deadline without significantly impacting the scope of our project***. However, if our request for a 1 year extension is approved we will be able to carefully and thoroughly submit this third RFP for all currently identified participants by mid-summer to be posted for 60 days and will expect implementation to be completed by the end of 2010.

IV. RHCPP Timeline Extension Request

June 2011 Update

a. GMTBI Request for 1 year Extension granted by FCC, **5/03/2011**. Extension allows any RHCPP that has had at least one 466 Package approved before 7/1/2011 one more year to submit 466 Packages for additional proposals/phases funding commitment by USAC. RFP01 is expecting Funding Commitment notification in June, 2011. RFP02 is scheduled to be posted in August 2011 and the 466 package submitted in Jan 2012 and FCL notification by March 2012.

March 2011 Update

b. FCC Comment on Indiana Project Request 1 year Extension submitted **1/5/2011** by GMTBI Steering Committee Chair: Maureen Ideker.
c. GMTBI Request for 1 year Extension submitted **2/18/2011** by GMTBI Project Coordinator, Kap Wilkes

March 2010 Update: The FCC ruled to extend the RHCPP deadline for all participating pilot projects to 6/39/2010. This extension will allow the GMTBI to successful implement RFP02.

December 2009 GMTBI work plan:
Seeking an extension of one year of the RHCPP filing deadline of 6/30/2010. This took the form of a written request to Thomas Buckley, FCC, from Greater Minnesota Telehealth Broadband Initiative (GMTBI) Project Coordinator asking to be considered along with other RHCPP projects that are requesting an extension. The FCC decision of an extension for all RHCPP projects is tied to the North Carolina Telehealth Network request, DA 09-2609.

9. Provide detail on whether network is or will become self sustaining. Selected participants should provide an explanation of how network is self sustaining.

The GMTBI steering committee did not complete a sustainability plan before 12/2011. However, it has been agree that at a minimum, SISU medical Systems will create a subscription fee that will cover the ongoing maintenance and support of the Network Operating Center (NOC). The NOC will be responsible for maintaining and updating and supporting the backbone circuits between regional hub POP locations, namely, SISU-Duluth, Altru-Grand Forks, Essential-Fargo, Rice-Willmar, and Northern Pines-Brainerd. As of 12/2011, it was agreed that SISU would create a subscription rate that will cover the human resources, facilities, and administrative costs for business hours 8-5 pm Monday – Friday and an on-call urgent downtime after hour support for the remaining hours of the week. Additionally it was agreed that SISU will complete the billing and collection of this subscription fee as a three year agreement directly with each participating HCP and collect in annual increments. Any HCP that decides to make a commitment to circuit connection to the GMTBI backbone is required to also enter into the subscription agreement with the NOC organization, SISU medical systems.
~~Sustainability Plan revisions will be approved by the GMTBI steering committee in November, 2s 011.~~

Sustainability plan of the GMTBI is under current consideration and revision by the GMTBI Steering Committee. Discussions center around NOC management and subscription fee structure for participating HCP's. Revisions are expected to be finalized by the end of September, 2011.

Sustainability plan revised ver 5.27.2010, included in quarterly report as **Addendum B.**

10. Provide detail on how the supported network has advanced telemedicine benefits:

a. Explain how the supported network has achieved the goals and objectives outlined in selected participant's Pilot Program application;
b. Explain how the supported network has brought the benefits of innovative telehealth and, in particular, telemedicine services to those areas of the country where the need for those benefits is most acute;
c. Explain how the supported network has allowed patients access to critically needed medical specialists in a variety of practices without leaving their homes or communities;
d. Explain how the supported network has allowed health care providers access to government research institutions, and/or academic, public, and private health care institutions that are repositories of medical expertise and information;
e. Explain how the supported network has allowed health care professional to monitor critically ill patients at multiple locations around the clock, provide access to advanced applications in continuing education and research, and/or enhanced the health care community's ability to provide a rapid and coordinated response in the event of a national crisis.

Not Applicable at this point in time.

11. Provide detail on how the supported network has complied with HHS health IT initiatives:

a. Explain how the supported network has used health IT systems and products that meet interoperability standards recognized by the HHS Secretary;
b. Explain how the supported network has used health IT products certified by the Certification Commission for Healthcare Information Technology;
c. Explain how the supported network has supported the Nationwide Health Information Network (NHIN) architecture by coordinating activities with organizations performing NHIN trial implementations;
d. Explain how the supported network has used resources available at HHS's Agency for Healthcare Research and Quality (AHRQ) National Resource Center for Health Information Technology;
e. Explain how the selected participant has educated themselves concerning the Pandemic and All Hazards Preparedness Act and coordinated with the HHS Assistant Secretary for Public Response as a resource for telehealth inventory and for the implementation of other preparedness and response initiatives; and
f. Explain how the supported network has used resources available through HHS's Centers for Disease Control and Prevention (CDC) Public Health Information Network (PHIN) to facilitate interoperability with public health and emergency organizations.

Not Applicable at this point in time.

12. Explain how the selected participants coordinated in the use of their health care networks with the Department of Health and Human Services (HHS) and, in particular, with its Centers for Disease Control and Prevention (CDC) in instances of national, regional, or local public health emergencies (*e.g.*, pandemics, bioterrorism). In such instances, where feasible, explain how selected participants provided access to their supported networks to HHS, including CDC, and other public health officials.

Not Applicable at this point in time.

Addendum A: Revised for phase 3 eligibility as of 9/2011 for a total of 131 unique termination points. GMTBI Participant Listing as of 6/30/2010, added contact information 10/30/2010. Revised 1/28/2011 to include actual sites for RFP00 465, RFP01 465, and Planned sties for RFP02 465. Sites listed in alphabetical order without RFP designation. Revised as of 4/19/2011 to include actual sites for RFP00, RFP01, and RFP02 with a total of 144 termination points, Ownership includes: Not For Profit (NFP), Rural Health Clinic (RHC), Community Mental Health Clinic (CMHC), Urban Health Clinic (UHC) Community Health Center providing healthcare to Migrant people (CHC Migrant).

Addendum A: *Listed in alphabetical order.* Revised for phase 3 eligibility as of 9/2011 for a total of 131 unique termination points *Ownership includes: Not For Profit (NFP), Rural Health Clinic (RHC), Community Mental Health Clinic (CMHC), Urban Health Clinic (UHC) Community* Health Center providing healthcare to Migrant people (CHC Migrant). RUCA will be completed with the next quarterly report.

HCP	Address	City	State	ZIP	County	RUCA	Ownership
Altru Health Systems	1200 S. Columbia Rd	Grand Forks	ND	58201	Grand Forks	1	NFP
Bigfork Valley Balsam Clinic	41150 Scenic Hwy. 7	Bovey	MN	55709	Itasca		RHC
Bigfork Valley Big Fork Hospital	258 Pine Tree Drive	Bigfork	MN	56628	Itasca	10.6	NFP
Bigfork Valley Marcell Clinic	49103 St. Hwy 38, P.O. Box 74	Marcell	MN	56657	Itasca		RHC
Cavalier County Memorial Hospital	909 2nd St.	Landgon	ND	58429	Cavalier		NFP
Children's Mental Health Services Grand Rapids	35382 US Hwy 2 West	Grand Rapids	MN	55774	Itasca		CMHC
Clearwater Health Services	203 4th St. NW	Bagley	MN	56621	Clearwater		NFP
Cloquet Community Memorial Hospital	512 Skyline Blvd.	Cloquet	MN	55720	Carlton	4	NFP
Cook County North Shore Hospital & Care Center	515 5th Ave. W.	Grand Marais	MN	55604	Cook	10	NFP
Cook Hospital	10 Fifth Street SE	Cook	MN	55723	St. Louis	6	NFP
Cooperstown Medical Center	1200 Roberts Ave. NE	Cooperstown	ND	58425	Griggs		NFP
Cuyuna Regional Medical Center	320 East Main Street	Crosby	MN	56441	Crow Wing	7.4	NFP
Deer River HealthCare Center	1002 Comstock Drive	Deer River	MN	56636	Itasca	10	NFP
Ely-Bloomenson Community Hospital	328 West Conan Street	Ely	MN	55731	St. Louis	7.3	NFP
Essentia Ada Bridges Medical Center	201 9th Street West	Ada	MN	56510	Norman		NFP
Essentia Aurora Clinic	405 W 3rd Avenue N	Aurora	MN	55705	St. Louis		RHC
Essentia Aurora Northern Pines Clinic	5211 Highway 110	Aurora	MN	55705	St. Louis		RHC
Essentia Babbitt Clinic	45 N Drive	Babbit	MN	55706	St. Louis		RHC

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HCP	Address	City	State	ZIP	County	RUCA	Ownership
Essentia Baxter Convenient Care	14133 Edgewood Drive	Baxter	MN	56401	Crow Wing		RHC
Essentia Brainerd Medical Center	2024 South 6th Street	Brainerd	MN	56401	Crow Wing		NFP
Essentia Casselton Clinic	5 Ninth Avenue N	Casselton	ND	58012	Cass		RHC
Essentia Chisholm Clinic	400 NW First Street	Chisholm	MN	55719	St. Louis		RHC
Essentia Chokio Clinic	101 Main Street	Chokio	MN	56221	Stevens		RHC
Essentia Deer River Clinic	1025 10th Avenue NE	Deer River	MN	56636	Itasca		RHC
Essentia Duluth Family Practice Clinic	330 North 8th Avenue East	Duluth	MN	55807	St. Louis		UHC
Essentia Duluth Lakeside Clinic	4621 E Superior Street	Duluth	MN	55804	St. Louis		UHC
Essentia Duluth West Clinic	4212 Grand Avenue	Duluth	MN	55807	St. Louis		UHC
Essentia Erskine Clinic	101 Vance Ave.	Erskine	MN	56535	Polk		RHC
Essentia Fargo 32nd Avenue Clinic	3000 32nd Avenue	Fargo	ND	58103	Cass		UHC
Essentia Fargo South University Clinic	1702 South University Drive	Fargo	ND	58103	Cass		UHC
Essentia Fargo West Acres Clinic	3902 13th Avenue South	Fargo	ND	58103	Cass		UHC
Essentia Fosston First Care Medical Services	900 Hilligoss Blvd. SE	Fosston	MN	56542	Polk		NFP
Essentia Graceville Holy Trinity Hospital	115 W 2nd Street	Graceville	MN	56240	Big Stone		NFP
Essentia Hackensack Clinic	110 3rd Street South	Hackensack	MN	56452	Cass		RHC
Essentia Hankinson Clinic	501 Main Avenue South	Hankinson	ND	58041	Richland		RHC
Essentia Hermantown Clinic	4855 W Arrowhead Road	Hermantown	MN	55811	St. Louis		UHC
Essentia Hibbing Clinic	730 E 34th St	Hibbing	MN	55746	St. Louis		RHC
Essentia Jamestown Clinic	401 Third Street SE	Jamestown	ND	58401	Stutsman		UHC
Essentia Lisbon Clinic	819 Main Street	Lisbon	ND	58054	Ransom		RHC
Essentia Mahnomen Clinic	117 North Main Street	Mahnomen	MN	56557	Mahnomen		RHC
Essentia Medina Clinic	600 Water Street East	Medina	ND	58467	Stutsman		RHC
Essentia Menahga Clinic	212 Aspen Avenue NE, P.O. Box 190	Menahga	MN	56464	Wadena		RHC
Essentia Moorhead Clinic	420 Center Avenue	Moorhead	MN	56560	Clay		UHC

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HCP	Address	City	State	ZIP	County	RUCA	Ownership
Essentia Oklee Clinic	Governor's St. & 3rd Ave	Oklee	MN	56742	Red Lake		RHC
Essentia Park Rapids Clinic	705 Pleasant Avenue	Park Rapids	MN	56470	Hubbard		RHC
Essentia Remer Clinic	9 Birch Street	Remer	MN	56672	Cass		RHC
Essentia St. Joseph's Brainerd Clinic	523 North 3rd Street	Brainerd	MN	56401	Crow Wing		UHC
Essentia St. Joseph's Brainerd Lakes Urology Clinic	1903 S 6th Street, Suite 3	Brainerd	MN	56401	Crow Wing		UHC
Essentia St. Joseph's Crosslake Clinic	35205 County Road 3 P.O. Box 470	Crosslake	MN	56442	Crow Wing		RHC
Essentia St. Joseph's Pequot Lakes Clinic	4317 West Woodman St, P.O. Box 356	Pequot Lakes	MN	56472	Crow Wing		RHC
Essentia St. Joseph's Pierz Clinic	221 North Main, P.O. Box 216	Pierz	MN	56364	Morrison		RHC
Essentia St. Joseph's Pillager Clinic	680 Pillsbury St. No.	Pillager	MN	56473	Cass		RHC
Essentia St. Joseph's Pine River Clinic	415 Barclay Avenue, P.O. Box 88	Pine River	MN	56474	Cass		RHC
Essentia St. Mary's Frazee Clinic	125 Frazee Street East	Detroit Lakes	MN	56504	Becker		RHC
Essentia St. Mary's Innovis Health	1027 Washington Avenue	Detroit Lakes	MN	56501	Becker		NFP
Essentia St. Mary's Lake Park Clinic	1005 First Street	Lake Park	MN	56554	Becker		RHC
Essentia Valley City Clinic	132 Fourth Avenue Northeast	Valley City	ND	58072	Barnes		RHC
Essentia Wahpeton Clinic	275 South 11th Street	Wahpeton	ND	58075	Richland		RHC
Essentia Walker Clinic	110 D Michigan Ave NW	Walker	MN	56484	Cass		RHC
Essentia West Fargo Clinic	1401 13th Avenue East	West Fargo	ND	58078	Cass		UHC
Fairview Health Services	400 Roosevelt St SE	Minneapolis	MN	55413	Hennepin		NFP
Family Life Center Coon Rapids	1930 Coon Rapids Blvd.	Coon Rapids	MN	55433	Anoka		CMHC
Family Life Center Lindstrom	13265 Sylvan Ave.	Lindstrom	MN	55045	Chisago		CMHC
First Care Health Center	115 Vivian St., PO Box 1	Park River	ND	58270	Walsh		NFP
FirstLight Hospital	301 South Hwy 65	Mora	MN	55051	Kanabec	8.3	NFP
Fraser Child and Family Center Anoka	2829 Verndale Ave	Anoka	MN	55303	Anoka		CMHC
Fraser Child and Family Center Bloomington	1801 American Blvd, Suite 1	Bloomington	MN	55425	Hennepin		CMHC

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HCP	Address	City	State	ZIP	County	RUCA	Ownership
Fraser Child and Family Center Minneapolis	3333 University Ave S.E.	Minneapolis	MN	55414	Hennepin		CMHC
Grand Itasca Clinic and Hospital	1601 Golf Course Rd.	Grand Rapids	MN	55744	Itasca		NFP
Human Development Center 1401 Duluth	1401 E. 1st St.	Duluth	MN	55085	St. Louis		CMHC
Human Development Center 1500 Duluth	1500 N 34th St.	Superior	WI	54880	Douglas		CMHC
Human Development Center 1730 Duluth	1730 E. Superior St.	Duluth	MN	55805	St. Louis		CMHC
Human Development Center 1807	1807 W. Hwy 61	Grand Marais	MN	55604	Cook		CMHC
Human Development Center 215 Duluth	215 N. Central Ave.	Duluth	MN	55807	St. Louis		CMHC
Human Development Center 40 Duluth	40 11th St.	Cloquet	MN	55720	Car		CMHC
Human Development Center 629 Duluth	629 1st Ave.	Two Harbors	MN	55616	Lake		CMHC
Hutchinson Area Health Care	1095 Highway 15 South	Hutchinson	MN	55350	McCleod	4	NFP
Johnson Memorial Health Services	1282 Walnut Street	Dawson	MN	56232	Lac qui Parle		NFP
Kittson Memorial Healthcare Center	1010 S. Birch, PO Box 700	Hallock	MN	56728	Kittson		NFP
Kittson Memorial Healthcare Karlstad Clinic	1st St S. AT Roosevelt Ave W.	Karlstad	MN	56732	Kittson	10	RHC
Lakeland Mental Health Center Alexandria	700 Cedar St. Suite 154	Alexandria	MN	56308	Douglas	4	CMHC
Lakeland Mental Health Center Detroit Lakes	928 8th St.	Detroit Lakes	MN	56501	Becker	4	CMHC
Lakeland Mental Health Center Fergus Falls	21333 County Hwy 1	Fergus Falls	MN	56537	Otter Tail	4	CMHC
Lakeland Mental Health Center Glennwood	100 17th Ave NW Suite 2	Glenwood	MN	56334	Pope	4	CMHC
Lakeland Mental Health Center Moorhead	1010 32nd Ave S.	Moorhead	MN	56560	Clay	4	CMHC
LakeWood Health Center Baudette	600 Main Ave. S.	Baudette	MN	56623	Lake of the Woods		NFP
Lifecare Medical Center Greenbush	19120 200th Street	Greenbush	MN	56726	Roseau		RHC
Lifecare Medical Center Roseau	715 Delmore Dr.	Roseau	MN	56751	Roseau		RHC

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HCP	Address	City	State	ZIP	County	RUCA	Ownership
Mercy Hospital & Healthcare Center	710 South Kenwood Ave	Moose Lake	MN	55767	Carlton	10.5	NFP
Migrant Health Grafton Clinic	701 W 6th Street	Grafton	ND	58237	Walsh		CHC Migrant
Migrant Health Moorhead Clinic	810 4th Ave S, Suite 101	Moorhead	MN	56560	Clay		CHC Migrant
Migrant Health Rochester Clinic	1926 Collegeview Rd SE	Rochester	MN	55904	Olmsted		CHC Migrant
Migrant Health Willmar Clinic	130 SE Willmar Avenue	Willmar	MN	56201	Kandiyohi		CHC Migrant
Murray County Medical Center	2042 Juniper Avenue	Slayton	MN	56172	Murray		NFP
Nelson County Health System Hospital & Clinic	200 N. Main St.	McVille	ND	58254	Nelson		NFP
North Region Health Alliance	115 S. Main St., Suite 4	Warren	MN	56762	Marshall		
North Valley Health Center	109 S. Minnesota St.	Warren	MN	56762	Marshall		NFP
Northern Pines Mental Health Center Brainerd 520	520 NW 5th St.	Brainerd	MN	56401	Crow Wing	7.3	CMHC
Northern Pines Mental Health Center Brainerd 823	823 Maple Street	Brainerd	MN	56401	Crow Wing	7.3	CMHC
Northern Pines Mental Health Center Little Falls	1906 5th Ave. SE	Little Falls	MN	56345	Morrison		CMHC
Northern Pines Mental Health Center Long Prairie	16 9th St SE	Long Prairie	MN	56347	Todd	7.3	CMHC
Northern Pines Mental Health Center Staples	616 4th St NE	Staples	MN	56479	Todd	7.3	CMHC
Northwestern Mental Health Center Crookston Bruce	603 Bruce St.	Crookston	MN	56716	Polk		CMHC

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HCP	Address	City	State	ZIP	County	RUCA	Ownership
Pembina County Memorial Hospital	301 Mountain St. E., PO Box 380	Cavalier	ND	58220	Cavalier		NFP
Range Mental Health Center Hibbing	3203 W. 3rd Ave	Hibbing	MN	55792	St. Louis		CMHC
Range Mental Health Center Virginia 504	504 1st St. N.	Virginia	MN	55792	St. Louis		CMHC
Range Mental Health Center Virginia 624	624 S. 13th St.	Virginia	MN	55792	St. Louis		CMHC
Regina Medical Center	1175 Nininger Road	Hastings	MN	55033	Dakota	4.1	NFP
Renville County Hector Clinic	131 Birch Avenue	Hector	MN	55342	Renville		RHC
Renville County Hospital	611 E. Fairview Ave.	Olivia	MN	56277	Renville		NFP
Renville County Olivia Clinic	600 East Park	Olivia	MN	56277	Renville		RHC
Renville County Renville Clinic	420 North Main St.	Renville	MN	56284	Renville		RHC
Rice Memorial Hospital	301 Becker Ave SW	Willmar	MN	56201	Kandiyohi		NFP
River's Edge Le Center Clinic	200 East Bowler Street	Le Center	MN	56057	Le Seuer		RHC
River's Edge St. Peter Hospital	1900 N. Sunrise Dr.	St. Peter	MN	56082	Nicollet		NFP
Riverview Healthcare Association	323 S. Minnesota St.	Crookston	MN	56716	Polk	7	NFP
Riverwood Healthcare Center	200 Bunker Hill Drive	Aitkin	MN	56431	Aitkin	10	NFP
Riverwood Healthcare Center Garrison Clinic	27278 State Hwy. 18	Garrison	MN	56450	Crow Wing		RHC
Riverwood Healthcare Center McGregor Clinic	2 East Center Avenue	McGregor	MN	55760	Aitkin		RHC
Sibley Medical Center	601 W. Chandler Street	Arlington	MN	55307	Sibley		NFP
SISU Medical Systems	5 W. 1st St., Suite 200	Duluth	MN	55802	St. Louis		
Swift County-Benson Hospital	1815 Wisconsin Avenue	Benson	MN	56215	Swift		NFP
Swift County-Benson Hospital Counseling Associates	640 Atlantic Avenue	Benson	MN	56215	Swift		RHC
Union Hospital	42 6th Ave. SE	Mayville	ND	58257	Trail		NFP
United Hospital District	515 South Moore Street	Blue Earth	MN	56013	Blue Earth		NFP
Unity Medical Center	164 W. 13th St.	Grafton	ND	58237	Walsh		NFP

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HCP	Address	City	State	ZIP	County	RUCA	Ownership
Western Mental Health Center Canby	112 St. Olaf Ave. S.	Canby	MN	56220	Yellow Medicine		CMHC
Western Mental Health Center Granite Falls	818 Prentice St.	Granite Falls	MN	56241	Chippewa		CMHC
Western Mental Health Center Ivanhoe	336 E. George St.	Ivanhoe	MN	56142	Lincoln		CMHC
Western Mental Health Center Marshall	1212 E. College Dr.	Marshall	MN	56258	Marshall		CMHC
Western Mental Health Center Redwood Falls	205 S. Mill St	Redwood Falls	MN	56283	Redwood		CMHC

Addendum B: Sustainability Plan ver 5.27.2010– narrative and budget forecast

Greater Minnesota Telehealth/e-Health Broadband Initiative (GMBTI)

FCC Rural Health Care Pilot

SUSTAINABILITY PLAN

May 2010

GREATER MINNESOTA TELEHEALTH/E-HEALTH BROADBAND INITIATIVE

The Greater Minnesota Telehealth/e-Health Broadband Initiative (GMTBI) is an affiliation of several existing health care networks in Minnesota representing over 120 health care facilities that came together in 2007 to apply for funding under the FCC Rural Health Care Pilot. The partner networks include: Medi-Sota Inc, MN Telehealth Network, MN Association of Community Mental Health Program, North Region Health Alliance, and SISU Medical Solutions. Supporting organizations include the Minnesota Department of Health and the University of Minnesota.

LONGTERM GOALS OF GMTBI

- Interconnect the pilot sites identified in its 2007 application.
- Create a robust, reliable and secure network for regional and statewide health information exchange and telehealth, including but not limited to rural and urban hospitals, physician clinics, community clinics, community mental health centers, local and county public health and social service agencies, home health care agencies, long term care facilities, correctional facilities, tribal health facilities, K-12 and higher education, and patients' homes.
- Integrate established telecommunication networks serving various healthcare systems into a seamless broadband enabled telehealth and telemedicine delivery service infrastructure dedicated to improving access to health care across rural Minnesota and beyond.
- Promote technical standards and operational best practices to reduce costs, boost performance, and improve user-friendliness of telehealth application.

The GMTBI network plan builds upon existing network relationships, allowing participating facilities to interconnect with:

- Rural health care facilities within their region and in urban areas.
- The University of Minnesota Network and Minnesota State Colleges and Universities network including the regional higher education distance learning networks.
- MNET, the state network servicing all state, county, and city services and education.
- Other state health care system provider IP networks, i.e. Mayo, Allina, Fairview, etc.
- Neighboring state health care networks, i.e. Avera Telehealth and Iowa HealthNet Connect Internet2 and National Lambda Rail (national backbones).

Pilot GOVERNANCE: GMTBI STEERING COMMITTEE

The five Partner organizations have established through a Memorandum of Agreement a governing steering committee to ensure that development of the telehealth broadband network meets statewide goals.

The GMBTI Partner Networks and Steering Committee members have agreed to:

1) Represent the partner networks and its member facilities with 1 voting privilege per partner network for decisions and actions as required during the life of the pilot
2) Provide strategic direction and counsel to the Project Coordinator on the development and implementation of the network related to meeting the Partner organization's needs, GMTBI goals and objectives, and FCC rules
3) Develop and/or approve a project plan, including timelines and projected budget, for the Pilot.
4) Develop communications strategies, information pieces and marketing tools to assist potential sites in participating in the Pilot.
5) Conduct quarterly meetings, monthly conference calls and ad hoc discussions
6) Disseminate information to participating facilities
7) Maintain a GMTBI share point website to keep all steering committee members and participating Health Care Provider facilities informed of planning, progress and communications
8) Participate in the Request for Proposal (RFP) process, including thorough review and approval of RFPs and network plan(s) prior to submission, review of vendor bids and selection of vendor(s), and invoice reimbursement process.
9) Non-voting participation on the Steering Committee is open to supporting organizations and participating healthcare organization.

Pilot MANAGEMENT AND COORDINATION: Lead Organization

The GMTBI Steering Committee voted to have SISU Medical Systems, Inc. act as Project Lead Organization on their behalf in implementing the project. Mark Schmidt, SISU CIO, is the FCC's named Project Coordinator on behalf of SISU; Jeff Plunkett and Kap Wilkes are the associate project coordinators on behalf of SISU. The Project Coordinator assigns associate project coordinators as needed to assist in the project management and technical implementation of the RHCPP on behalf of GMTBI.

SISU Medical Systems has the technical knowledge and expertise to develop and design the network plan and the organizational capacity to coordinate the USAC funding process. It is an IT organization supporting a consortium of 16 rural healthcare facilities. SISU has a 10-year proven and successful track record of managed collaboration and existing technical infrastructure in a position to contribute on a state level, thus strengthening the long-term sustainability of the project.

The Lead Organization and Project Coordinator, SISU Medical Systems, has agreed under direction and approval from the GMTBI Steering Committee to:

1) Act on behalf of the GMTBI before the Federal Communications Commission (FCC) in matters related to the Rural Health Care Pilot Program (Pilot), submit all forms, attachments, and reports necessary to the FCC and/or the USAC Rural Health Care Division.
2) Appoint staff to act as project manager(s) to support their lead organization role for the Pilot in a manner consistent of the long term vision and goals of the GMTBI Steering Committee and in accordance with FCC rules.
3) Work with GMTBI Steering Committee representatives and participating sites to identify needs, develop requests for proposal for telecommunications services, review and select vendors
4) Complete and implement a network plan that meets GMTBI goals and objectives
5) Provide technical assistance to sites to advise on installation of selected hardware and services as appropriate, but not bid on or provide any of the services that require bidding, including installation.
6) Continue to follow any applicable federal, state or local procurement rules and retain all documentation of activities related to the Pilot Program for five years from the end of the last funding year.

PHASED APPROACH TO IMPLEMENT GMTBI FCC PILOT

A phased approach to implement the project was adopted in order to meet priority needs, build organizational capacity and processes, and complete the 3-5 year plan.

- **Phase I Objective:** Immediately meet the needs of eight participating facilities that lacked any level of broadband and build the organizational capacity required to manage the project, while building individual facility participation through outreach and education.
- **Phase II Objective:** Build a centrally managed hub and regional nodes capable of supporting addition of remaining sites to the network in Phase III.
- **Phase III Objective:** Add all remaining sites identified in the FCC application.

In addition to meeting immediate and long-term needs, the phased approach:

- Builds organizational and administrative capacity of SISU Medical Systems required to manage the project, including processes for submission of USAC forms, selection of vendors, and quarterly reporting during the duration of the project.
- Builds individual facility participation through marketing, outreach and education by GMTBI Steering Committee members and SISU Medical Systems.
- Contributes to long-term sustainability of the network by ensuring that facility participation in the network provides value by building upon existing health care business relationships and referral

patterns, and providing needed connections for health information exchange, meaningful use of electronic health records, and telehealth services.

GMTBI Network Design

The GMTBI network will provide broadband connectivity to all participating HCP through 2 regional nodes and 1 central hub. This design allows local sites in the network to share health information or Telehealth services with other healthcare locations in Minnesota and western North Dakota, and ultimately, with other health care providers regionally and nationally. We are currently designing Phase II of our network to incorporate MPLS technology and programming. A complete written description and network diagram will be included in the next quarterly report, June, 2010.

Summary Financial Plan

For the initial pilot build-out of our GMTBI network there will be a combination of onetime equipment/infrastructure costs and recurring connectivity costs. This summary financial budget has been created based on the FCC Pilot application and updated with infrastructure Equipment/infrastructure 1-time cost estimates for the 2 regional nodes and central hub hardware, as of May, 2010.

GMTBI Summary Forecast 10 Yr Budget of GMTBI Network

		RHC Pilot Project 15% hardware + circuit costs)					RHC Primary Mechanism (50% circuit costs)					
		2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**GMTBI TOTAL**
Estimated costs :												
	Network Infrastructure: Nodes & Hub											
	Equipment Cost (2)	$24,900	$99,600									$124,500
	Annual Circuit cost (3)		$6,705	$26,820	$26,820	$26,820	$89,400	$89,400	$89,400	$89,400	$89,400	$534,165
	HCP Circuits											
	Equipment Cost (4)	$4,500	$137,400									$141,900
	Annual Circuit cost (5)		$16,200	$162,000	$162,000	$162,000	$540,000	$540,000	$540,000	$540,000	$540,000	$3,202,200
	Estimated Network Hardware and Circuit COSTS	**$29,400**	**$259,905**	**$188,820**	**$188,820**	**$188,820**	**$629,400**	**$629,400**	**$629,400**	**$629,400**	**$629,400**	**$4,002,765**

	Pilot Project Coordination (6)	$45,000	$67,500									$112,500
	On-Going Network Support (7)			$81,000	$82,620	$84,272	$85,958	$87,677	$89,431	$91,219	$93,044	$695,220
	On-Going Network Administration (7)			$30,375	$30,983	$31,602	$32,234	$32,879	$33,536	$34,207	$34,891	
	Estimated Network Management Cost	**$45,000**	**$67,500**	**$111,375**	**$113,603**	**$115,875**	**$118,192**	**$120,556**	**$122,967**	**$125,426**	**$127,935**	**$807,720**
TOTAL COSTS		**$74,400**	**$327,405**	**$300,195**	**$302,423**	**$304,695**	**$747,592**	**$749,956**	**$752,367**	**$754,826**	**$757,335**	**$4,810,485**

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		RHC Pilot Project 15% hardware + circuit costs)					RHC Primary Mechanism (50% circuit costs)					
		2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	GMTBI TOTAL
Estimated Income												
	HCP 15% Match during Pilot	$29,400	$259,905	$188,820	$188,820	$188,820						$855,765
	HCP circuit costs estimated through Primary USAC funding mechanism (10)						$629,400	$629,400	$629,400	$629,400	$629,400	$3,147,000
	HCP LOA Admin Fee (8)	$24,375	$8,125									$32,500
	MN Dept of Health Grant	$41,250	$41,250									$82,500
	HCP Network Management Cost Sharing (9)	-$20,625	$18,125	$111,375	$113,603	$115,875	$118,192	$120,556	$122,967	$125,426	$127,935	$692,720
TOTAL INCOME		**$74,400**	**$327,405**	**$300,195**	**$302,423**	**$304,695**	**$747,592**	**$749,956**	**$752,367**	**$754,826**	**$757,335**	**$4,810,485**

Assumptions and Definitions:

1	The costs in this spreadsheet include only the 15% that the GMTBI HCP's , nodes, and hubs incur
2	RFP00 includes equipment costs for one node and three HCP's in late 2009, the remaining nodes and central hub are included in RFP01 which is planned for Fall 2010
3	RFP01 is planned to have active circuits in Fall 2010
4	3 HCPs had equipment installed in Fall-Winter 2009 through RFP00
5	Approximately 10% of circuits were activated in 2010 through RFP00
6	Project Coordination includes network design, RFP writing, project management, quarterly reports, sustainability plan writing, HCP communication, steering committee

7	On-going network support assumes 1 FTE for support for hardware, router programming, changes, and .75 FTE for network administration assistance with the USAC invoicing mechanisms. These payroll costs include a 2% annual increase
8	HCP LOA administrative fee includes $500 per HCP organization that signed a LOA. It is for pilot administration and project coordination
9	HCP Network Management Cost Sharing is a concept where all participating HCP organizations that sign a LOA and participate on the GMTBI network also participate in sharing the cost of ongoing network management. This has not been needed during the first two years of the pilot because of the LOA Admin Fee and the MDH grant.
10	It is not known at the time of creating this spreadsheet what the HCP circuit costs will be after the transition from the pilot to the Primary USAC mechanism. However, the responsibility of the operational expense of the GMTBI circuits is assumed to be beneficial for participating HCP and expected to take place.

Administrative support of the RHCPP invoicing process: The administrative cost in terms of human resources has been a burden to the Project Coordinator organization, SISU Medical Systems. Some costs have been offset by two sources, State of Minnesota Office of Rural Health and Primary Care, grant for 2009- 2010, $85,000 and HCP $500 participation fee, as of May, 2010 . But considerable time has been volunteered. Likewise GMTBI Steering Committee members and participating HCP IT Staff have also been volunteering their time to participate in the pilot. The Steering Committee will continue to work toward identifying ways to sustain the GMTNI beyond the Pilot Project. Following are some of ideas that have been discussed.

Sustainability beyond Pilot Project

- Looking beyond the pilot, each participating HCP has budgeted for return to the subsidy provided under the Primary USAC program.
- Reimbursements for telehealth services by Minnesota health plans, Medicare, and Medicaid, are continuing to improve and help facilities in recovering costs for telecommunications and telehealth equipment and associated costs.
- Minnesota's Critical Access Hospitals, which make up a significant number of facilities in the GMTBI, will continue participate in the Medicare Rural Hospital Flexibility Program cost-based reimbursement and cost-reporting, including the match required under the primary USAC subsidy.
- Current Minnesota law requires all health care providers to utilize e-prescribing for all prescriptions by 2011 and have interoperable electronic health records by 2015.
- The Medicare and Medicaid HITECH Act incentives will contribute an important source of recovery for achieving interoperability for health information exchange and eCare/telehealth for Minnesota providers, including those participating in the GMTBI and those brought into the network in the future. Imposed penalties beginning in 2016 are motivating all of Minnesota's providers to resolve their connectivity and interoperability issues by said date.
- Realized savings to participating HCPs from reduced drive time, health care provider and physician time, will offer value to facilities for telehealth and eCare application.
- Identification of additional funding opportunities to support e-Health applications and collaborations are available through HRSA's Office of Rural Health Policy, Office of Advancement for Telehealth, USDA Rural Development, Minnesota's Rural Hospital Flexibility Program sub-grants, and foundation funding, such as the Helmsley Trust and Robert Wood Johnson Foundation.
- Continuation of the GMTBI Steering Committee or similar statewide coordinating board will ensure support for continued growth of the network and support access to grant opportunities listed above.
- Continuation of support from the Minnesota Department of Health, the University of Minnesota, the Minnesota Telehealth Registry, and the Great Plains Telehealth Resource Center will ensure that the GMTBI network continues to coordinate with other state and regional efforts.
- Plans for continued marketing and outreach efforts to expand network membership to facilities not currently included in the pilot will create additional support for long-term sustainability.